This screening tool is to be used based on Centers for Disease Control and Prevention recommended guidelines. The assessment must be completed by an authorized health care professional – a registered nurse or a physician.

**Facility Name:** _____

**Name:** _____ **Screening Date:** _____

**Association with Facility:** ☐ Resident/Participant ☐ Employee

| Symptoms | Yes | No |
|---|---|---|
| Persistent Cough (>3 weeks) | ☐ | ☐ |
| Bloody Sputum | ☐ | ☐ |
| Night Sweats | ☐ | ☐ |
| Loss of Appetite | ☐ | ☐ |
| Unexplained Weight Loss | ☐ | ☐ |
| Unexplained Fever | ☐ | ☐ |

If any of the above symptoms are displayed a PPD or chest x-ray must be completed.

**Indicate if Completed:** ☐ PPD ☐ Chest X-ray

_____ _____
Physician Signature Date

_____ _____
RN Signature Date